

Amevive (Alefaccept) Prior Authorization Request Form



5577

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER
and
RETAIL

- The provider may **call**: **1-866-684-4488**
or the completed form may be **faxed** to:
1-866-684-4477

- The patient may attach the completed form
to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
or **email** the form only to:

TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: **Amevive (alefacept)**

Step 1 Please complete patient and physician information (Please Print)

1 Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
Sponsor ID #: _____ Phone #: _____
Date of Birth: _____ Secure Fax #: _____

Step 2 Please complete the clinical assessment

| | | |
|--|---|---|
| 1. Is the patient less than 18 years of age? | <input type="checkbox"/> Yes Coverage not approved | <input type="checkbox"/> No Please proceed to Question 2 |
| 2. Is the patient immunocompromised (e.g., due to HIV or other etiology), and/or does the patient have a CD4+ lymphocyte count below normal at start of treatment? | <input type="checkbox"/> Yes Coverage not approved | <input type="checkbox"/> No Please proceed to Question 3 |
| 3. Will the patient receive concomitant therapy with another immunosuppressive agent or phototherapy? | <input type="checkbox"/> Yes Coverage not approved | <input type="checkbox"/> No Please proceed to Question 4 |
| 4. Is Amevive being prescribed for the treatment of chronic moderate to severe plaque psoriasis in which systemic therapy or phototherapy is indicated? | <input type="checkbox"/> Yes Please sign and date | <input type="checkbox"/> No Coverage not approved |

Quantity Limits: limited to a 4 week supply in retail.

Step 3 I certify the above is true to the best of my knowledge.

3 Please sign and date:

Prescriber Signature

Date

Latest revision: February 2008